

Title: Decision-Making for Unrepresented Patients

I. POLICY

It is the policy of [HOSPITAL NAME] that a patient who lacks decision-making capacity, has no Advance Directive or POLST form, and has no Legal Representative or Surrogate, may have routine treatment decisions made directly by the patient's Physician of Record. Decisions to provide major invasive treatments or to withhold or withdraw life-sustaining treatments (including CPR) are subject to a Special Ethics Review prior to implementation. The intent of the Special Ethics Review process, defined herein, is to advise whether the proposed action is in the patient's best interest.

II. DEFINITIONS

- A. *Decision-Making Capacity* – a patient's ability to understand the nature and consequences of a healthcare decision relative to his or her care, including significant benefits, risks, and alternatives, and to communicate a decision.
- B. *Advance Directive* – a written instruction that relates to the provision of healthcare to be used when a patient lacks decision-making capacity and hence is unable to participate in his or her own healthcare decision-making. This includes written expression of preferences and values regarding healthcare choices and/or authorization of another person to make healthcare decisions on behalf of the patient.
- C. *POLST* – a *Physician Orders for Life Sustaining Treatment* form, approved by the California Legislature, which indicates previously ordered medical interventions to be provided or withheld for a patient (based on, at the time of completion, the patient's medical condition and preferences) and which the patient or the patient's Legal Representative or Surrogate is responsible to present upon arrival to the Emergency Department or admission to the hospital (or as soon after as possible).
- D. *Legal Representative* – an individual authorized to make healthcare decisions for a patient due to appointment by the Courts to be the patient's Conservator or designated in a Power of Attorney for Health Care (or other legally-recognized Advance Directive) to be the patient's Agent or Attorney-in-Fact.
- E. *Surrogate Decision-Maker* – an adult recognized to make decisions for the patient when there is no Legal Representative.
- F. *Physician of Record* – a member of the Medical Staff who, without reference to Medical Staff membership category, is the principal provider of professional services to the patient during hospitalization and directs the care for that patient during the course of the stay as evidenced by signed written orders and progress notes. The Physician of Record may designate another Physician or a Licensed Independent Practitioner to act on his or her behalf.
- G. *Physician* – a member of the Medical Staff with appropriate clinical privileges to provide indicated medical services.

- H. *Licensed Independent Practitioner* – a member of the Medical Staff who holds a License or a Physician-in-Training who holds a License and who is enrolled in an approved postgraduate Physician-in-Training program at the Medical Center where engaging in the practice of medicine is required as part of such training program.
- I. *Routine Treatment* – medical intervention that does not pose significant risk to the patient’s health or life, and about which major differences in personal, social or religious values are unusual. This generally includes individual interventions and procedures for which signed informed consent is normally not required or for which signed informed consent is normally required but are considered low risk. Examples of routine treatment may include, but are not limited to: administration of parenteral medications, transfusion of blood products, routine laboratory and radiographic diagnostics, radiographic procedures involving contrast dye, placement of intravenous access, biopsies that do not invade a body cavity, and some invasive diagnostic procedures (abdominal paracentesis, spinal tap, etc.).
- J. *Major Invasive Treatment* – medical intervention for which there is substantial risk to the patient for serious injury, significant suffering, or death, or for which there is a reasonable likelihood of major differences in personal, social or religious values. This includes most, but not all, individual interventions for which signed informed consent is normally required. Examples of major invasive treatment may include, but are not limited to: most surgery, most invasive diagnostic and therapeutic procedures, interventions that carry substantial morbidity or mortality risk (such as cancer chemotherapy), or lower risk interventions that imply large decisions about overall treatment goals (dialysis, feeding gastrostomy, tracheostomy, etc.).
- K. *Life-sustaining Treatment* – medical intervention without which there is reasonable medical expectation the patient will die within a brief time period.
- L. *Best Interest* – a standard which, at minimum, takes into consideration the patient’s preferences and values to the extent these are known or discoverable, the likelihood that hoped for patient benefits will outweigh foreseeable patient burdens, and whether the anticipated results will be abusive or neglectful of the patient and the patient’s needs.

III. PURPOSE

To delineate standardized processes for making medical decisions for patients who lack decision-making capacity, have no advance healthcare directive or POLST form, and have no Legal Representative or Surrogate Decision-Maker.

IV. PROCEDURE

NON-EMERGENT DECISIONS

- A. The Physician of Record (or designee), with assistance from consulting physicians if appropriate, will determine and document in the patient’s medical record that the patient lacks Decision-Making Capacity.

- B. The Social Worker or Case Manager assigned to the patient (or other individuals charged with or participating in this task) will determine after a diligent search, and document in the patient's medical record, that:
1. no Advance Directive or POLST form has been discovered; and
 2. no Legal Representative or Surrogate has been identified, or if a Legal Representative or Surrogate has been identified, he or she is unable or unwilling to participate in decision-making.

The Social Worker or Case Manager assigned to the patient (or other individuals charged with or participating in this task) should continue the search for a Legal Representative or Surrogate throughout the patient's hospital stay (as is appropriate and feasible), even while the procedures below are being implemented. Similarly, initiation of the process to appoint a legal guardian for the patient should be initiated when feasible.

C. DECISIONS ABOUT ROUTINE TREATMENTS

1. The Physician of Record (or designee) may perform or order any and all routine treatments he or she determines to be medically appropriate.
2. If there is uncertainty regarding whether providing routine treatment is in the patient's best interest, the Physician of Record (or designee) should consult with another physician and/or obtain a Clinical Ethics Consultation. The Physician of Record (or designee) may perform or order any and all routine treatment he or she subsequently determines to be in the patient's best interest.
3. If there is explicit disagreement among physicians caring for the patient regarding whether providing routine treatment is in the patient's best interest, the Physician of Record (or designee) shall obtain a Clinical Ethics Consultation. The Physician of Record (or designee) may perform or order any and all routine treatment he or she subsequently determines to be in the patient's best interest. Other members of the patient's care team shall request a Clinical Ethics Consultation should they have questions about, or disagree with, the determination that providing routine treatment is in the patient's best interest.
4. The Physician of Record (or designee) shall document in the patient's medical record the basis upon which treatments are determined to be in the patient's best interest.

D. DECISIONS ABOUT MAJOR INVASIVE TREATMENT OR TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENTS

1. The Physician of Record (or designee) shall document in the patient's medical record the basis upon which the provision of major invasive treatments or the withholding or withdrawal of life-sustaining treatments are determined to be in the patient's best interest.
2. The Physician of Record (or designee) should contact his or her Departmental Chair (or designee) who will subsequently facilitate obtaining a written consultation from another physician regarding whether or not the provision of major invasive treatments or the withholding or withdrawal of life-sustaining treatments is in the patient's best interest. The other physician should not be directly involved in the care of the patient and should have relevant qualifications to provide a second medical opinion.
3. The Physician of Record (or designee) shall obtain a Clinical Ethics Consultation. In addition to the usual activities associated with Clinical Ethics Consultation, the Clinical Ethics Consultant shall initiate a Special Ethics Review.

4. Special Ethics Review
 - a. The Clinical Ethics Consultant shall assemble an *ad hoc* Special Ethics Review committee (“SER”) in a timely manner.
 - i. The SER will consist of an interdisciplinary group of no less than two (2) additional individuals to be drawn preferentially from the membership of [HOSPITAL NAME]’s Bioethics Committee.
 - ii. At least one of the additional individuals on the SER should be a non direct-provider of patient care, e.g., a case manager, a chaplain, a lay member of the Bioethics Committee, a representative from Patient Relations, or a social worker (or similarly-trained personnel).
 - iii. To avoid potential conflicts of interest or commitment, none of the individuals on the SER shall be directly involved in providing care to the patient.
 - b. The SER shall meet with the Physician of Record (or designee) and review the pertinent information relevant to the proposal that to initiate major invasive treatment, or withhold or order the withdrawal of life-sustaining treatment, is in the patient’s best interest.
 - i. Other personnel directly involved in the care of the patient, including consulting physicians, staff nurses, etc., may be asked or may request to attend this meeting. Other Medical Center personnel whose input is deemed useful for determining the patient’s best interests may also be asked to attend this meeting.
 - ii. If any of the other personnel listed immediately above in section IV.D.4.b.i are unable to attend this meeting, the SER may gather their input independent of this meeting.
 - c. At the conclusion of this meeting, or in a timely manner following its conclusion, the SER will provide the Physician of Record (or designee) with a recommendation regarding whether the proposal to initiate major invasive treatments or withhold or order the withdrawal of life-sustaining treatments is in the patient’s best interest. The Clinical Ethics Consultant will document the recommendation of the SER in the patient’s medical record. Such documentation shall include, but is not limited to, the basis upon which the recommendation is believed to be in the patient’s best interest.
 - d. In addition to recommendations regarding the provision, withholding, or withdrawal of specific treatments, the SER may also provide recommendations pertinent to the establishment of appropriate goals of treatment, including relative bounds or limits for future interventions.
5. The Physician of Record (or designee) may perform or order major invasive treatments, or may withhold or order the withdrawal of life-sustaining treatments, which promote the patient’s best interest.
6. If the Physician of Record (or designee) disagrees with the SER’s recommendation regarding which actions promote the patient’s best interest, the Physician of Record (or designee) may seek addition input from at least the following individuals, for the sake of reviewing the specific issues and address the differences of opinion between the Physician of Record (or designee) and the SER:
 - a. additional physicians whose training and experience is relevant to the patient’s situation;
 - b. the Physician of Record (or designee)’s Clinical Chief or Department Chair (or their designees);

c. representatives from Risk Management;

After additional consideration, the Physician of Record (or designee) may proceed with a treatment plan he/she believes promotes the patient's best interests. This plan may include any, all, or none of the SER's recommendations. The Physician of Record (or designee) must document in the patient's medical record why he/she believes this plan promotes the patient's best interests. Such documentation should include reference to all additional consultation and input sought, if any.

The Physician of Record (or designee) may also seek transfer of the patient to another Physician of Record or another facility if the patient's status is sufficiently stable.

EMERGENT DECISIONS

E. Under the following conditions, the Physician of Record (or designee) may perform, or order the provision or withholding of, medical treatment (whether such treatment is routine, major invasive, or life-sustaining):

1. the Physician of Record (or designee) has determined that
 - a. the patient lacks Decision-Making Capacity, and
 - b. emergent initiation, or withholding, of medical treatment is in the patient's best interest;¹
2. no Advance Healthcare Directive or POLST form has been discovered, and/or no Legal Representative or Surrogate has been identified, and a diligent search for these has not been completed.

F. If there is disagreement with other care providers directly involved in the care of the patient, or uncertainty, regarding whether initiating or withholding emergent medical treatment (whether routine, major invasive or life-sustaining) is in the patient's best interest, the Physician of Record (or designee) should (if time allows) consult with another physician and/or obtain a Clinical Ethics Consultation. Whether such consultation occurs or not, the Physician of Record (or designee) may perform, or order the provision or withholding of, medical treatment he or she determines to be in the patient's best interest.

G. The decision to provide medical treatment (whether such treatment is routine, major invasive, or life-sustaining) or to withhold life-sustaining treatment must be supported by documentation in the medical record by the Physician of Record (or designee) Such documentation should include, but is not limited to:

1. a summary of the patient's medical situation, including medical status, diagnosis, and prognosis, at the time the decision was made to provide or withhold medical treatment;
2. opinions, findings, and recommendations from appropriate consultants, if any;
3. the basis upon which the patient was determined to lack Decision-Making Capacity and the extent of efforts made to discover an Advance Healthcare Directive or POLST form and/or identify a Legal Representative or Surrogate;
4. the basis regarding why the decision was believed to be in the patient's best interest.

¹ While a physician must use his or her best medical judgment when determining whether withholding medical treatment is in a patient's best interest, withholding medical treatment determined to be medically inappropriate is always taken to be in a patient's best interest (see Section IVE: Conditions In Which Life-Sustaining Treatments are Considered Medically Inappropriate, of the "Withholding and Withdrawing of Life-Sustaining Treatment" policy).

V. RELATED POLICIES AND PROCEDURES

- Clinical Ethics Consultation
- Determination of Death
- Health Care Decisions
- Withholding and Withdrawing of Life-Sustaining Treatment